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## ON PREMISES LICENSE RENEWAL APPLICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | IDGE                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| APPLICATION FOR RENEWAL: Seasonal LICENSED FOR 20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 013                             |
| CLASS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | YEAR                            |
| LICENSEE NAME: BERKSHIRE THEATRE FESTIVAL, THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                 |
| DOING BUSINESS A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |
| ADDRESS N/S EAST MAIN ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                 |
| CITY/TOWN: STOCKBRIDGE STATE: MA ZIP CODE: 01262                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |
| MANAGER: MAGUIRE, TYPE OF LICENSE:Restaurant CATEGORY: KATHLEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Wine and<br>Malt Regular        |
| EMAIL ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                 |
| PLEASE ALSO VISIT OUR WEBSITE AND ENTER YOUR EMAIL ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | _                               |
| DESCRIPTION OF LICENSED PREMISES:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |
| EXISTING SMALL CONCESSION STAND ON THE NORTH SIDE OF THE PLAYHOUSE BUILDIN IS LOCATED ON THE NORTH SIDE OF EAST MAIN STREET AND THE WEST SIDE OF YALE HE ROAD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                 |
| I hereby certify and swear under penalties of perjury that:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |
| 1. the renewed license will be of the same type for the same premises now licensed;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |
| 2. the licensee has complied with all laws of the Commonwealth relating to taxes; and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                 |
| 3. the premises are now open for business (If not explain below)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |
| SIGNED BY:  Individual, Partner or Authorized Corporate Officer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |
| Individual, Partner or Authorized Corporate Officer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TION NUMBER:                    |
| Individual, Partner or Authorized Corporate Officer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |
| Individual, Partner or Authorized Corporate Officer  DATE: TELEPHONE NUMBER: EMPLOYER IDENTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | eer 304 of the above            |
| DATE:  TELEPHONE NUMBER:  EMPLOYER IDENTIFICAT (Note: NOT Individual Social Section 2004, signed by the building inspector and the head of the fire department for the named license and (2) the certificate of liquor liability insurance required by Chapter 116 of 2010.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | er 304 of the above of the Acts |
| DATE:  TELEPHONE NUMBER:  EMPLOYER IDENTIFICAT (Note: NOT Individual Social St.)  We the undersigned, attest that we are in possession (1) the certificate required by Chapter Acts of 2004, signed by the building inspector and the head of the fire department for the named license and (2) the certificate of liquor liability insurance required by Chapter 116 of 2010.  Please Check Below:  LOCAL LICENSING AUTHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | er 304 of the above of the Acts |
| DATE: TELEPHONE NUMBER: EMPLOYER IDENTIFICAT (Note: NOT Individual Social St.)  We the undersigned, attest that we are in possession (1) the certificate required by Chapter Acts of 2004, signed by the building inspector and the head of the fire department for the named license and (2) the certificate of liquor liability insurance required by Chapter 116 of 2010.  Please Check Below: LOCAL LICENSING AUTHO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | er 304 of the above of the Acts |
| Individual, Partner or Authorized Corporate Officer  DATE: TELEPHONE NUMBER: EMPLOYER IDENTIFICAT (Note: NOT Individual Social St.)  We the undersigned, attest that we are in possession (1) the certificate required by Chapter Acts of 2004, signed by the building inspector and the head of the fire department for the named license and (2) the certificate of liquor liability insurance required by Chapter 116 of 2010.  Please Check Below:  APPROVED: LOCAL LICENSING AUTHORS By:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | er 304 of the above of the Acts |
| Individual, Partner or Authorized Corporate Officer  DATE: TELEPHONE NUMBER: EMPLOYER IDENTIFICAT (Note: NOT Individual Social Set Note: N | er 304 of the above of the Acts |



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## ON PREMISES LICENSE RENEWAL APPLICATION

| LICENSE NUMBE        | R: 124000011                                                               |                         | CITY OR TOWN          | STOCKBR          | IDGE                     |
|----------------------|----------------------------------------------------------------------------|-------------------------|-----------------------|------------------|--------------------------|
| APPLICATION FO       | R RENEWAL:                                                                 | Seasonal                | LICEN                 | SED FOR 20       | 013                      |
|                      |                                                                            | CLASS                   |                       |                  | YEAR                     |
| LICENSEE NAME        | BOSTON SYMPH                                                               | ONY ORCHESTRA           | A                     |                  |                          |
| DOING BUSINESS       | S A                                                                        |                         |                       |                  |                          |
| ADDRESS WEST         | & HAWTHORNE ST                                                             |                         |                       |                  |                          |
| CITY/TOWN: STO       | OCKBRIDGE                                                                  | STATE: MA               | ZIP CODE:             | 01262            |                          |
| MANAGER: NOI         | LTEMY, KIM TYP                                                             | PE OF LICENSE:Re        | estaurant CA          | ATEGORY:         | Wine and<br>Malt Regular |
| EMAIL ADDRESS        | :                                                                          |                         |                       |                  | ]                        |
|                      | PLEASE ALSO VISIT OUR WE                                                   | EBSITE AND ENTER YOUR F | EMAIL ADDRESS         |                  | _                        |
|                      | LICENSED PREMIS                                                            | SES:                    |                       |                  |                          |
| TANGLEWOOD CA        |                                                                            |                         |                       |                  |                          |
| •                    | swear under penalties                                                      |                         |                       |                  |                          |
| 1. the renev         | ved license will be of                                                     | the same type for the   | e same premises now   | licensed;        |                          |
| 2. the licens        | see has complied with                                                      | all laws of the Com     | monwealth relating to | o taxes; and     |                          |
| 3. the prem          | ises are now open for                                                      | business (If not exp    | lain below)           |                  |                          |
|                      |                                                                            |                         |                       |                  |                          |
| SIGNED BY:           |                                                                            |                         | 0.00                  |                  |                          |
|                      | Individual, Partner                                                        | or Authorized Corp      | orate Officer         |                  |                          |
|                      |                                                                            |                         |                       |                  |                          |
|                      |                                                                            |                         |                       |                  |                          |
| DATE:                | TELEPHON                                                                   | E NUMBER:               |                       |                  | TION NUMBER:             |
|                      |                                                                            |                         | (Note: NOT Ind        | ividuai Sociai S | ecurity Number)          |
| Acts of 2004, signe  | ed, attest that we are<br>ed by the building ins<br>(2) the certificate of | spector and the hea     | d of the fire departi | ment for the     | above                    |
| Please Check Below:  |                                                                            |                         | LOCAL LICENS          | ING AUTH         | ORITY                    |
| APPROVED:            |                                                                            |                         | By:                   |                  |                          |
| DISAPPROVED:         |                                                                            |                         |                       |                  |                          |
| (If disapproved expl | ain)                                                                       |                         |                       |                  |                          |
|                      |                                                                            |                         |                       |                  |                          |
| DATE:                |                                                                            |                         |                       |                  |                          |
| <i>ν</i> .11μ.       |                                                                            |                         |                       |                  |                          |



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## ON PREMISES LICENSE RENEWAL APPLICATION

| LICENSE NUMBER: 1240                                                                               | 00024              |                | (          | CITY OR TO                     | NWC              | STOCKBR                     | LIDGE                            |
|----------------------------------------------------------------------------------------------------|--------------------|----------------|------------|--------------------------------|------------------|-----------------------------|----------------------------------|
| APPLICATION FOR REN                                                                                | EWAL:              | Season         | nal        | L                              | ICEN             | SED FOR 20                  | 013                              |
|                                                                                                    |                    | CLAS           | SS         |                                |                  |                             | YEAR                             |
| LICENSEE NAME: BOS DOING BUSINESS A TA                                                             |                    |                |            | NC                             |                  |                             |                                  |
| ADDRESS 114 INTERLA                                                                                |                    |                |            |                                |                  |                             |                                  |
| CITY/TOWN: STOCKBR                                                                                 | RIDGE              | STATE:         | MA         | ZIP COD                        | DE:              | 01262                       |                                  |
| MANAGER: NOLTEMY                                                                                   | , KIM TYPE         | E OF LICEN     | SE:Resta   | urant                          | CA               | ATEGORY:                    | Wine and<br>Malt Regular         |
| EMAIL ADDRESS:                                                                                     |                    |                |            |                                |                  |                             |                                  |
| PLEASE A                                                                                           | ALSO VISIT OUR WEB | SITE AND ENTER | YOUR EMA   | IL ADDRESS                     |                  |                             | _                                |
| DESCRIPTION OF LICEN                                                                               | ISED PREMISE       | ES:            |            |                                |                  |                             |                                  |
| ONE SMALL ROOM, 2 COO<br>OUTSIDE GRASS TERRACH<br>ENTRANCE AND EXIT                                |                    |                |            |                                |                  |                             | Γ.                               |
| I hereby certify and swear u                                                                       | nder penalties o   | of perjury tha | t:         |                                |                  |                             |                                  |
| 1. the renewed lice                                                                                | nse will be of th  | e same type    | for the sa | ime premise                    | s now            | licensed;                   |                                  |
| 2. the licensee has                                                                                | complied with a    | ll laws of the | Commo      | nwealth rela                   | ating to         | taxes; and                  |                                  |
| 3. the premises are                                                                                | now open for b     | usiness (If no | ot explair | below)                         |                  |                             |                                  |
| SIGNED BY:                                                                                         | vidual, Partner o  | r Authorized   | l Corpora  | ite Officer                    |                  |                             |                                  |
|                                                                                                    |                    |                |            |                                |                  |                             |                                  |
| DATE:                                                                                              | TELEPHONE          | NUMBER:        |            |                                |                  |                             | FION NUMBER:<br>Security Number) |
| We the undersigned, atterded to the Acts of 2004, signed by the named license and (2) the of 2010. | e building insp    | ector and th   | ne head o  | certificate r<br>of the fire d | equiro<br>eparti | ed by Chapt<br>nent for the | er 304 of the above              |
| Please Check Below:                                                                                |                    |                |            | LOCAL LI                       | CENS             | ING AUTHO                   | ORITY                            |
| APPROVED:                                                                                          |                    |                |            | By:                            |                  |                             |                                  |
| DISAPPROVED:                                                                                       |                    |                |            |                                |                  |                             |                                  |
| (If disapproved explain)                                                                           |                    |                |            |                                |                  |                             |                                  |
|                                                                                                    |                    |                |            |                                |                  |                             |                                  |
| DATE:                                                                                              |                    |                |            |                                |                  |                             |                                  |



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## ON PREMISES LICENSE RENEWAL APPLICATION

|                          | CITY OR TOWN STOCKBR                                                                                                                                                                                                                                                                                                                        | IDGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Seasonal                 | LICENSED FOR 20                                                                                                                                                                                                                                                                                                                             | 013                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| CLASS                    |                                                                                                                                                                                                                                                                                                                                             | YEAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| HONY ORCHESTRA,          | INC                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| (GRILL)                  |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| STATE: MA                | ZIP CODE: 01262                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| PE OF LICENSE:Rest       | aurant CATEGORY:                                                                                                                                                                                                                                                                                                                            | Wine and<br>Malt Regular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| EBSITE AND ENTER YOUR EM | AIL ADDRESS                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| SES:                     |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| SPHALT PATIO BORDI       |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| s of perjury that:       |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| the same type for the s  | same premises now licensed;                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| n all laws of the Comm   | onwealth relating to taxes; and                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| business (If not explain | in below)                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| r or Authorized Corpor   | rate Officer                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| IE NUMBER:               | EMPLOYER IDENTIFICAT                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          | (Note: NOT Individual Social S                                                                                                                                                                                                                                                                                                              | Security Number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| spector and the head     | of the fire department for the                                                                                                                                                                                                                                                                                                              | above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                          | LOCAL LICENSING AUTHO                                                                                                                                                                                                                                                                                                                       | ORITY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                          | By:                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                          | Seasonal CLASS HONY ORCHESTRA, D (GRILL)  STATE: MA PE OF LICENSE: Rest VEBSITE AND ENTER YOUR EM SES: LL STORAGE ROOM A SPHALT PATIO BORDITANCE s of perjury that: If the same type for the shall laws of the Comm or business (If not explain r or Authorized Corporation of the NUMBER:  The in possession (1) the ispector and the head | Seasonal LICENSED FOR 20 CLASS HONY ORCHESTRA, INC D (GRILL)  STATE: MA ZIP CODE: 01262 PE OF LICENSE:Restaurant CATEGORY:  VEBSITE AND ENTER YOUR EMAIL ADDRESS SES: LL STORAGE ROOM AND ONE UTILITY ROOM, 5 EXI SPHALT PATIO BORDERED BY SHRUBBERY AND FE TRANCE s of perjury that: It he same type for the same premises now licensed; In all laws of the Commonwealth relating to taxes; and It business (If not explain below)  TO Authorized Corporate Officer  WE NUMBER:  EMPLOYER IDENTIFICAT (Note: NOT Individual Social S  BE in possession (1) the certificate required by Chapte aspector and the head of the fire department for the In the sum of the sum |



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## ON PREMISES LICENSE RENEWAL APPLICATION

|                                                                                                                   | : 124000027                                                 |                                      | -                      |                                                                       | N STOCKBR                                                                  | ID GE                           |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------|------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------|
| APPLICATION FOR                                                                                                   | RENEWAL:                                                    | Season                               | nal                    | LICE                                                                  | ENSED FOR 20                                                               | )13                             |
|                                                                                                                   |                                                             | CLAS                                 | SS                     |                                                                       |                                                                            | YEAR                            |
| LICENSEE NAME:                                                                                                    |                                                             |                                      |                        |                                                                       |                                                                            |                                 |
| DOING BUSINESS A                                                                                                  |                                                             | )D-HIGHWOOD                          | BUILDI                 | NG                                                                    |                                                                            |                                 |
| ADDRESS 2 HAWTI                                                                                                   | HORNE ST                                                    |                                      |                        |                                                                       |                                                                            |                                 |
| CITY/TOWN: STOC                                                                                                   | CKBRIDGE                                                    | STATE:                               | MA                     | ZIP CODE:                                                             | 01262                                                                      |                                 |
| MANAGER: NOLT                                                                                                     | TEMY, KIM T                                                 | YPE OF LICENS                        | SE:Club                |                                                                       | CATEGORY:                                                                  | All Alcohol                     |
| EMAIL ADDRESS:                                                                                                    |                                                             |                                      |                        |                                                                       |                                                                            |                                 |
| P                                                                                                                 | LEASE ALSO VISIT OUR                                        | R WEBSITE AND ENTER                  | YOUR EMAIL             | ADDRESS                                                               |                                                                            | _                               |
| DESCRIPTION OF L                                                                                                  | LICENSED PREM                                               | AISES:                               |                        |                                                                       |                                                                            |                                 |
| HIGHWOOD HOUSE OF WING FOR STORAGE WITH 4 MEETING RO                                                              | AND 2 BATHRO                                                | OMS, 1340 SF, 2 C                    | OUTDOOR                | PATIOS WIT                                                            |                                                                            |                                 |
| I hereby certify and sv                                                                                           | wear under penalt                                           | ies of perjury that                  | t:                     |                                                                       |                                                                            |                                 |
| 1. the renewe                                                                                                     | ed license will be                                          | of the same type t                   | for the san            | ne premises no                                                        | ow licensed;                                                               |                                 |
| 2. the license                                                                                                    | e has complied w                                            | ith all laws of the                  | Common                 | wealth relatin                                                        | g to taxes; and                                                            |                                 |
| 3. the premise                                                                                                    | es are now open f                                           | for business (If no                  | ot explain b           | pelow)                                                                |                                                                            |                                 |
| SIGNED BY:                                                                                                        | Individual, Parti                                           | ner or Authorized                    | Corporate              | Officer                                                               |                                                                            |                                 |
|                                                                                                                   |                                                             |                                      |                        |                                                                       |                                                                            |                                 |
|                                                                                                                   |                                                             |                                      |                        |                                                                       |                                                                            |                                 |
| DATE:                                                                                                             | TEL EDIL                                                    |                                      |                        | EMBI OX                                                               | ZED IDENITIEICAT                                                           | NON NI IMPED.                   |
| DATE:                                                                                                             | TELEPHO                                                     | ONE NUMBER:                          |                        |                                                                       | ZER IDENTIFICAT                                                            |                                 |
| DATE:  We the undersigned Acts of 2004, signed named license and (2 of 2010.                                      | , attest that we a<br>by the building                       | re in possession<br>inspector and th | e head of              | (Note: <u>NOT</u><br>rtificate requ<br>the fire depa                  | Individual Social S<br>nired by Chapt<br>ortment for the                   | er 304 of the above             |
| We the undersigned<br>Acts of 2004, signed<br>named license and (2                                                | , attest that we a<br>by the building                       | re in possession<br>inspector and th | e head of<br>y insuran | (Note: <u>NOT</u><br>rtificate requ<br>the fire depa<br>ce required l | Individual Social S<br>nired by Chapt<br>ortment for the                   | er 304 of the above of the Acts |
| We the undersigned Acts of 2004, signed named license and (2 of 2010.  Please Check Below: APPROVED:              | , attest that we a<br>by the building                       | re in possession<br>inspector and th | e head of<br>y insuran | (Note: <u>NOT</u><br>rtificate requ<br>the fire depa<br>ce required l | Individual Social S<br>nired by Chapt<br>ortment for the<br>by Chapter 116 | er 304 of the above of the Acts |
| We the undersigned Acts of 2004, signed named license and (2 of 2010.  Please Check Below: APPROVED: DISAPPROVED: | , attest that we a<br>by the building<br>2) the certificate | re in possession<br>inspector and th | e head of<br>y insuran | (Note: NOT rtificate requ the fire depa ce required l                 | Individual Social S<br>nired by Chapt<br>ortment for the<br>by Chapter 116 | er 304 of the above of the Acts |
| We the undersigned Acts of 2004, signed named license and (2 of 2010.  Please Check Below: APPROVED:              | , attest that we a<br>by the building<br>2) the certificate | re in possession<br>inspector and th | e head of<br>y insuran | (Note: NOT rtificate requ the fire depa ce required l                 | Individual Social S<br>nired by Chapt<br>ortment for the<br>by Chapter 116 | er 304 of the above of the Acts |
| We the undersigned Acts of 2004, signed named license and (2 of 2010.  Please Check Below: APPROVED: DISAPPROVED: | , attest that we a<br>by the building<br>2) the certificate | re in possession<br>inspector and th | e head of<br>y insuran | (Note: NOT rtificate requ the fire depa ce required l                 | Individual Social S<br>nired by Chapt<br>ortment for the<br>by Chapter 116 | er 304 of the above of the Acts |



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## ON PREMISES LICENSE RENEWAL APPLICATION

| LICENSE NUMBER: 124000028                                                                                     |                                  | CITY OR TOWN         | STOCKBRIDGE                     |   |
|---------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------|---------------------------------|---|
| APPLICATION FOR RENEWAL                                                                                       | : Seasonal                       | LICEN                | SED FOR 2013                    |   |
|                                                                                                               | CLASS                            |                      | YEAR                            |   |
| LICENSEE NAME: BOSTON S DOING BUSINESS A TANGLEY                                                              |                                  |                      |                                 |   |
| ADDRESS 3 HAWTHORNE RD                                                                                        |                                  |                      |                                 |   |
| CITY/TOWN: STOCKBRIDGE                                                                                        | STATE: MA                        | ZIP CODE:            | 01262                           |   |
| MANAGER: NOLTEMY, KIM                                                                                         | TYPE OF LICENSE:Gene             |                      | ATEGORY: All Alcohol            |   |
| EMAIL ADDRESS:                                                                                                |                                  |                      |                                 |   |
| PLEASE ALSO VISI                                                                                              | T OUR WEBSITE AND ENTER YOUR EM. | AIL ADDRESS          |                                 |   |
| DESCRIPTION OF LICENSED P                                                                                     | REMISES:                         |                      |                                 |   |
| HAWTHORNE TENT 7200 SQ FT LOSTANCHIONS, WEATHER DEPENDENCE                                                    |                                  |                      |                                 |   |
| I hereby certify and swear under pe                                                                           | enalties of perjury that:        |                      |                                 |   |
| 1. the renewed license wil                                                                                    | l be of the same type for the s  | same premises now    | licensed;                       |   |
| 2. the licensee has complied                                                                                  | ed with all laws of the Comm     | onwealth relating to | o taxes; and                    |   |
| =                                                                                                             | pen for business (If not explai  | _                    |                                 |   |
|                                                                                                               |                                  |                      |                                 |   |
| SIGNED BY:                                                                                                    |                                  |                      |                                 |   |
|                                                                                                               | Partner or Authorized Corpor     | ate Officer          |                                 |   |
|                                                                                                               |                                  |                      |                                 | 7 |
|                                                                                                               |                                  |                      |                                 |   |
| DATE: TELE                                                                                                    | EPHONE NUMBER:                   | EMPLOYER             | IDENTIFICATION NUMBER:          |   |
| 122                                                                                                           | 2 1101 (2 1 (01)1221)            | (Note: NOT Ind       | ividual Social Security Number) |   |
| We the undersigned, attest that Acts of 2004, signed by the build named license and (2) the certific of 2010. | ling inspector and the head      | of the fire departs  | ment for the above              |   |
| Please Check Below:                                                                                           |                                  | LOCAL LICENS         | ING AUTHORITY                   |   |
| APPROVED:                                                                                                     |                                  | By:                  |                                 |   |
| DISAPPROVED:                                                                                                  |                                  | •                    |                                 |   |
| (If disapproved explain)                                                                                      |                                  |                      |                                 |   |
|                                                                                                               |                                  |                      |                                 |   |
| DATE:                                                                                                         |                                  |                      |                                 |   |



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## ON PREMISES LICENSE RENEWAL APPLICATION

| LICENSE NUM                | MBER: 124000029                                                         |                            | CI                  | TY OR TOW     | N STOCKBR       | IDGE                     |
|----------------------------|-------------------------------------------------------------------------|----------------------------|---------------------|---------------|-----------------|--------------------------|
| APPLICATION                | FOR RENEWAL:                                                            | Seasonal LICENSED FOR 2013 |                     |               |                 | )13                      |
|                            |                                                                         | CLAS                       | SS                  |               |                 | YEAR                     |
|                            | ME: BOSTON SY                                                           |                            |                     | IC            |                 |                          |
| ADDRESS 2 H                | AWTHORNE ST                                                             |                            |                     |               |                 |                          |
| CITY/TOWN:                 | STOCKBRIDGE                                                             | STATE:                     | MA                  | ZIP CODE:     | 01262           |                          |
| MANAGER:                   | NOLTEMY, KIM                                                            | TYPE OF LICENS             | SE:Genera<br>premis |               | CATEGORY:       | Wine and<br>Malt Regular |
| EMAIL ADDR                 | ESS:                                                                    |                            |                     |               |                 |                          |
|                            | PLEASE ALSO VISIT (                                                     | OUR WEBSITE AND ENTER      | YOUR EMAIL          | ADDRESS       |                 |                          |
| SINGLE TENT,               | N OF LICENSED PR<br>1800 SQ FT LOCATEI<br>TRANCE AND EXIT. (            | O WEST OF OZAWA            | HALL BO             | ORDERED BY    | A FENCE WITH    | I ONE                    |
| I hereby certify           | and swear under pen                                                     | alties of perjury tha      | t:                  |               |                 |                          |
|                            | enewed license will b                                                   |                            |                     | _             |                 |                          |
|                            | icensee has complied                                                    |                            |                     |               | g to taxes; and |                          |
| 3. the p                   | premises are now ope                                                    | n for business (If no      | ot explain          | below)        |                 |                          |
|                            |                                                                         |                            |                     |               |                 |                          |
| SIGNED BY:                 | Individual, Pa                                                          | artner or Authorized       | Corporate           | e Officer     |                 |                          |
|                            |                                                                         |                            |                     |               |                 |                          |
| DATE:                      | TELEP                                                                   | HONE NUMBER:               |                     |               | ER IDENTIFICAT  |                          |
| Acts of 2004, s            | signed, attest that w<br>signed by the buildir<br>and (2) the certifica | ng inspector and th        | e head of           | the fire depa | rtment for the  | above                    |
| Please Check Below         | <u>w:</u>                                                               |                            | I                   | LOCAL LICE    | NSING AUTHO     | ORITY                    |
| APPROVED:                  |                                                                         |                            | H                   | Ву:           |                 |                          |
| DISAPPROVE (If disapproved |                                                                         |                            |                     |               |                 |                          |
| (11 disappioved            | слріані)                                                                |                            | •                   |               |                 | _                        |
|                            |                                                                         |                            | •                   |               |                 |                          |
| DATE:                      |                                                                         |                            |                     |               |                 |                          |



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## ON PREMISES LICENSE RENEWAL APPLICATION

| LICENSE NU       | MBER: 124000030                                                                        |                       | CITY OR TO         | OWN STOCKB           | KIDGE            |
|------------------|----------------------------------------------------------------------------------------|-----------------------|--------------------|----------------------|------------------|
| APPLICATIO       | N FOR RENEWAL:                                                                         | Seasonal              | Ll                 | ICENSED FOR          | 2013             |
|                  |                                                                                        | CLASS                 |                    |                      | YEAR             |
| LICENSEE N.      | AME: BOSTON SYMPI                                                                      | HONY ORCHESTE         | RA,INC             |                      |                  |
| DOING BUSI       | NESS A TANGLEWOOI                                                                      | O-OZAWA HALL          | NORTH EAST T       | ENT                  |                  |
| ADDRESS 2 I      | HAWTHORNE ST                                                                           |                       |                    |                      |                  |
| CITY/TOWN:       | STOCKBRIDGE                                                                            | STATE: MA             | ZIP COD            | E: 01262             |                  |
| MANAGER:         | NOLTEMY, KIM TY                                                                        | PE OF LICENSE:        | General on oremise | CATEGORY             | : All Alcohol    |
| EMAIL ADDI       | RESS:                                                                                  |                       |                    |                      |                  |
|                  | PLEASE ALSO VISIT OUR V                                                                | VEBSITE AND ENTER YOU | R EMAIL ADDRESS    |                      |                  |
|                  | N OF LICENSED PREMI                                                                    |                       |                    |                      |                  |
|                  | . NE TENT, 2250 SQ FT, LC<br>.PACITY OF 150                                            | CTED NORTHEAST        | Γ OF OZAWA HA      | LL WITH ONE E        | NTRANCE          |
| I hereby certify | y and swear under penaltie                                                             | s of perjury that:    |                    |                      |                  |
| 1. the           | renewed license will be of                                                             | the same type for t   | he same premises   | s now licensed;      |                  |
| 2. the           | licensee has complied with                                                             | h all laws of the Co  | mmonwealth rela    | ting to taxes; and   | i                |
| 3. the           | premises are now open for                                                              | r business (If not ex | plain below)       |                      |                  |
|                  |                                                                                        |                       |                    |                      |                  |
| SIGNED BY:       |                                                                                        |                       |                    |                      |                  |
|                  | Individual, Partne                                                                     | r or Authorized Con   | rporate Officer    |                      |                  |
|                  |                                                                                        |                       |                    |                      |                  |
|                  |                                                                                        |                       |                    |                      |                  |
| DATE:            | TELEPHON                                                                               | NE NUMBER:            |                    | LOYER IDENTIFICA     |                  |
|                  |                                                                                        |                       | (Note: N           | OT Individual Social | Security Number) |
| Acts of 2004,    | rsigned, attest that we ar<br>signed by the building in<br>e and (2) the certificate o | spector and the ho    | ead of the fire de | epartment for th     | ne above         |
| Please Check Bel |                                                                                        |                       | LOCAL LIC          | CENSING AUTI         | HORITY           |
| APPROVED:        |                                                                                        |                       | By:                |                      |                  |
| DISAPPROVI       |                                                                                        |                       |                    |                      |                  |
| (If disapproved  | a explain)                                                                             |                       | <del></del>        |                      |                  |
|                  |                                                                                        |                       |                    |                      |                  |
| DATE:            |                                                                                        |                       |                    | -                    |                  |
|                  |                                                                                        |                       |                    |                      |                  |